School-Based Health Center Invoice Assessment Form

Massachusetts Department of Public Health

The following is an account of activity for services delivered for the MA Department of Public Health for the contract and month below:

Month:

Year (yyyy):

Contract #:

Form completed by: _____.

Please complete all questions for each of your SBHC sites individually.

Name of SBHC
Existing dropdown

 # Student Days this Month (should not exceed 23 days)

This Month's Hours of Operation

Actual Service Population Table
Please complete A-C. This table should be based on the month for which you are submitting an invoice.

	A	B	C
	Total school population this month	**Total # enrolled in SBHC this month**	**Total # visits this month**
TOTAL			

Other Monthly Staff Activities
This includes any staff activities (non-individual client related) not captured above that promote or integrate the health center or improve the health of the students. (Optional)

Please select the activities completed this month and enter the hours utilized by each staff type:

Therapeutic Groups

Yes/No

Medical Clinician Hours
Mental Health Clinician Hours
Administrative Assistant Hours
Program Manager Hours
Other (specify)_____
Other Hours:

Classroom Health Education

Yes/No

Medical Clinician Hours
Mental Health Clinician Hours
Administrative Assistant Hours
Program Manager Hours
Other (specify)_____
Other Hours:

Community Health Fair

Yes/No

Medical Clinician Hours
Mental Health Clinician Hours
Administrative Assistant Hours
Program Manager Hours
Other (specify)_____
Other Hours:

Outreach (school, community, parent)

Yes/No

Medical Clinician Hours
Mental Health Clinician Hours
Administrative Assistant Hours
Program Manager Hours
Other (specify)_____
Other Hours:

School-Wide Health Activities

Yes/No

Medical Clinician Hours
Mental Health Clinician Hours
Administrative Assistant Hours
Program Manager Hours
Other (specify)_____
Other Hours:

School Team Meeting

Yes/No

Medical Clinician Hours
Mental Health Clinician Hours
Administrative Assistant Hours
Program Manager Hours
Other (specify)_____
Other Hours:

SBHC or Agency Meeting

Yes/No

Medical Clinician Hours
Mental Health Clinician Hours
Administrative Assistant Hours
Program Manager Hours
Other (specify)_____
Other Hours:

Professional Development

Yes/No

Medical Clinician Hours
Mental Health Clinician Hours
Administrative Assistant Hours
Program Manager Hours
Other (specify)_____
Other Hours:

Other Meetings

Yes/No

Medical Clinician Hours
Mental Health Clinician Hours
Administrative Assistant Hours
Program Manager Hours
Other (specify)_____
Other Hours:

Paperwork

Yes/No

Medical Clinician Hours
Mental Health Clinician Hours
Administrative Assistant Hours
Program Manager Hours
Other (specify)_____
Other Hours:

Data Entry

Yes/No

Medical Clinician Hours
Mental Health Clinician Hours
Administrative Assistant Hours
Program Manager Hours
Other (specify)_____
Other Hours:

Do you have an additional SBHC to enter?

Yes/No